

# PATIENT SAFETY AND QUALITY CARE

A Handbook for Healthcare Professionals
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# **The Patient Safety Handbook**

Cynthia A. Oster, Jane S. Braaten

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and goes on to summarize each of the key patient safety requirements implemented by federal state and accreditation agencies including the federal Patient Safety and Ouality Improvement Act of 2005 The Handbook of Patient Safety Compliance Fay A. Rozovsky, James R. Woods, Jr., 2016-12-05 Written for virtually every professional and leader in the health care field as well as students who are preparing for careers in health services delivery this book presents a framework for developing a patient safety program shows how best to examine events that do occur and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness. The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatory compliance The role of accreditation and standard setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence based outcomes and standards of care Creation and preservation of reports data and device evidence in medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability based credentialing for health care professionals Planning for the future **Handbook of Perioperative and Procedural** Patient Safety Juan A Sanchez, Robert S. D. Higgins, Paula S. Kent, 2023-03-10 Offering a concise yet comprehensive review of current practices in surgery and patient safety Handbook of Perioperative and Procedural Patient Safety is an up to date practical resource for practicing surgeons anesthesiologists surgical nurses hospital administrators and surgical office staff Edited by Drs Juan A Sanchez and Robert S D Higgins and authored by expert contributors from Johns Hopkins it provides an expansive look at the scope of the problem causes of error minimizing errors surgical suite and surgical team design patient experience and other related topics Presents the knowledge and experience of a multidisciplinary team from Johns Hopkins University which created the Comprehensive Unit based Safety Program CUSP an approach for improving safety culture and engaging frontline clinicians to identify and mitigate defects in care delivery Discusses the scope and prevalence of perioperative harm causes of error in healthcare and perioperative never events Covers safe practices cognitive workload and fatigue and the effects of noise in the OR Includes several team based chapters such as the dynamics of surgical teams safer perioperative team communication and the culture of safety Consolidates today s available information and guidance into a single convenient resource High Reliability Organizations, Second Edition Cynthia A. Oster, Jane S. Braaten, 2020-11-02 Patient safety and quality of care are critical concerns of healthcare consumers payers providers organizations health systems and governments Although a strong body of knowledge shows that high reliability methods enable the most efficient safe and effective care these methods have yet to be completely implemented across healthcare According to authors Cynthia Oster and Jane Braaten nurses who are on the frontline of providing safe and effective care are ideally situated to drive high reliability High Reliability Organizations A Healthcare Handbook for Patient Safety Quality Second Edition equips nurses and healthcare professionals with the tools necessary to establish an error detection and

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